File ON Demand

FILED

Related DOJ

Name: JUAN CHAVEZ
Address: 334 S. Main, #1612
Los Angeles, CA 90013
Phone: (213) 257-7444
Fax:
In Pro Per

2024 MAR 19 PM 3:32
CLERK U.S. DISTRICT COURT
CENTRAL DIST. OF CALIF.
LOS ANGELES
BY:

3/18/24

UNITED STATES DISTRICT COURT

CENTRAL DISTRICT OF CALIFORNIA

juc012@g.harvard.edu

Plaintiff

v.

Thankyou@SSA.gov DOES

Defendant(s).

CASE NUMBER:

CV24 2234- DMG (MRW)

To be supplied by the Clerk of
The United States District Court

APA; SSA; Civil Rights Aj
ADA. ACTION

52/50 Gravely disabled deemed
" no longer disabled" enters reconsideration
same day notified of discontinuance.

MR. HEARVEY under Mentor Salazar
1401 W. 8th St. Los Angeles, CA 90013
(877) 803-4308 x 24680

exersising lengthy review of "showing of good cause"!

Form **SSA-789** (01-2019) UF
Discontinue Prior Editions
Social Security Administration

OMB No. 0960-0349

REQUEST FOR RECONSIDERATION - DISABILITY CESSATION RIGHT TO APPEAR

(SEE REVERSE SIDE FOR PAPERWORK/PRIVACY ACT NOTICE)

FOR SOCIAL SECURITY OFFICE USE ONLY **(DO NOT WRITE IN THIS SPACE)**

☐ FO Code _____

☐ Benefit Continuation

☐ Foreign Language Notice _____

NAME OF CLAIMANT	SOCIAL SECURITY NUMBER
JUAN PABLO CHAVEZ	452-81-8302
NAME OF WAGE EARNER OR SELF-EMPLOYED PERSON (if different from Claimant)	SOCIAL SECURITY NUMBER
SPOUSE'S NAME AND SOCIAL SECURITY NUMBER (COMPLETE ONLY IN SUPPLEMENTAL SECURITY INCOME CASE)	

TYPE OF BENEFIT	DISABILITY			SSI		
	☐ WORKER	☐ WIDOW	☐ CHILD	☒ DISABILITY	☐ BLIND	☐ CHILD

I DO NOT AGREE WITH THE DETERMINATION TO STOP DISABILITY BENEFITS AND I REQUEST RECONSIDERATION.

My reasons are (reasons should relate to the basis for stopping disability benefits and be as specific as possible):

NOTE: If the notice of the determination on your claim is dated more than 65 days ago, include your reason for not making this request earlier. Include the date on which you received the notice.

I did not receive doctor's appointments because of mail clerk err. Gravely Disabled
Dr. To (pronounced TOW) — (213) 893-5431 52/50

I AM SUBMITTING THE FOLLOWING ADDITIONAL INFORMATION (If "NONE" write "NONE")
(Attach additional page if needed):

Re-leased to Texas (DMV Shut down)
omnibused through MX Border

CHECK BLOCK 1 AND THE STATEMENTS THAT APPLY OR CHECK BLOCK 2

☒ 1. **I (and/or my representative) wish to appear** at a disability hearing. The disability hearing will be with a person called a disability hearing officer and it will let me explain why I do not agree with the decision to stop benefits.

☐ I need an interpreter at the disability hearing - Language _____
(If you need an interpreter, SSA will provide one at no cost to you.)

OR

☐ 2. **I do not wish to appear nor do I wish a representative to appear for me** at the disability hearing. I have been advised of my right to have a disability hearing. I understand that a disability hearing will give me a chance to present witnesses. It will also let me explain to the disability hearing officer why my disability benefits should not end. I understand that this chance to be seen and heard could help the disability hearing officer learn about the facts in my case. The disability hearing officer would give me a chance to have people who know about my condition give information and explain how my condition keeps me from working and restricts my activities. I have been told about my right to representation at the disability hearing, including representation by an attorney or other person of my choice. Although the above has been explained to me, I do not want to appear at a disability hearing, or have someone represent me at a disability hearing. I prefer to have the disability hearing officer decide my case on the evidence in my file, plus any evidence that I submit or that may be obtained by the Social Security Administration. I have been advised that if I change my mind, I can request a disability hearing prior to the writing of a decision in my case. In this case, I can make the request with any Social Security office.

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge. I understand that anyone who knowingly gives a false or misleading statement about a material fact in this information, or causes someone else to do so, commits a crime and may be sent to prison, or may face other penalties, or both.

EITHER THE CLAIMANT OR REPRESENTATIVE SHOULD SIGN - ENTER ADDRESSES FOR BOTH

CLAIMANT SIGNATURE			SIGNATURE OR NAME OF CLAIMANT'S REPRESENTATIVE		
STREET ADDRESS 334 S. Main St #1612			REPRESENTATIVE'S ADDRESS		
CITY Los Angeles	STATE CA	ZIP CODE 90013	CITY	STATE	ZIP CODE
TELEPHONE NUMBER (318) 523-1411	DATE 3/18/24 - 2/23/24 thinking of 3/4/24		TELEPHONE NUMBER	DATE	

Witnesses are required ONLY if this form has been signed by mark (X). If signed by mark (X), two witnesses to the signing who know the person requesting reconsideration must sign below, giving their full addresses.

1. SIGNATURE OF WITNESS	2. SIGNATURE OF WITNESS
ADDRESS (Number and Street, City, State, and ZIP Code)	ADDRESS (Number and Street, City, State, and ZIP Code)

Privacy Act Statement
Collection and Use of Personal Information

Sections 205 (a) and (b), and 1631 (c)(1)(A) and (B) of the Social Security Act, as amended, allow us to collect this information. Furnishing us this information is voluntary. However, failing to provide all or part of the information may prevent us from reconsidering a determination on your claim.

We will use the information to reconsider your eligibility for disability benefits. We may also share your information for the following purposes, called routine uses:

- To third party contacts where necessary to establish or verify information provided by representative payees or payee applicants; and,
- To third party contacts (including private collection agencies under contract with us) for the purpose of their assisting us in recovering overpayments.

In addition, we may share this information in accordance with the Privacy Act and other Federal laws. For example, where authorized, we may use and disclose this information in computer matching programs, in which our records are compared with other records to establish or verify a person's eligibility for Federal benefit programs and for repayment of incorrect or delinquent debts under these programs.

A list of additional routine uses is available in our Privacy Act System of Records Notices (SORN) 60-0009, entitled Hearings and Appeals Case Control System, as published in the Federal Register (FR) on October 13, 1982, at 47 FR 45589; 60-0010, entitled Hearing Office Tracking System of Claimant Cases, as published in the FR on January 11, 2006 at 71 FR 1806; and 60-0089, entitled Claims Folders Systems, as published in the FR on April 1, 2003, at 68 FR 15784. Additional information and a full listing of all our SORNs are available on our website at www.ssa.gov/privacy.

Paperwork Reduction Act Statement

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 13 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at www.socialsecurity.gov. Offices are also listed under U.S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213 (TTY 1-800-325-0778).** *You may send comments on our time estimate above to: SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***